

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08379

8380

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORDOVA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>LeRoy Anderson</u>				4. DATE OF DEATH <u>July 14 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1891</u>	9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>unknown</u>			
14. MOTHER'S MAIDEN NAME <u>HR Minth Anderson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>			
16. SOCIAL SECURITY NO. <u>unknown</u>				17. INFORMANT <u>Blake (Step-daughter)</u> Address <u>...</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Idiopathic cardiac hypertrophy</u> 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>2195 Washington St 16 July 58</u> ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D. <u>Easton 16 Md.</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>7/18/58</u>		<u>Skilton Cem</u>		<u>Easton Rt 2, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. McKel</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 17 58</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 8380

8381

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp</u>		d. STREET ADDRESS <u>FINCHVILLE</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl Bolden</u>		4. DATE OF DEATH <u>July 23 1958</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>Calvin Major Cephas</u>		14. MOTHER'S MAIDEN NAME <u>Odessa Bolden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Odessa Bolden (mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Hemorrhage</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 da</u> (c) <u>18 da</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-5-58</u> , to <u>7-23-58</u> , that I last saw the deceased alive on <u>7-23-58</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E Baybutt</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton, Md</u>	
PHYSICIAN'S NAME (Type) <u>JOHN E BAYBUTT</u>		DATE SIGNED <u>7/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 25, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FEDERAL HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Trampton & Son</u>		ADDRESS <u>Federalburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Search</u>	

2080225 XVI

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CERTIFICATE OF DEATH

2001

Reg. No. 100

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>DATE OF DEATH <i>10/10/1901</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>RESIDENCE <i>123 Main St. Baltimore, Md.</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>PERMANENT CAUSE <i>Arteriosclerosis</i></p>		<p>INTERESTING FACTS <i>Deceased was a heavy smoker.</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>John Doe, M.D.</i></p>		<p>SIGNATURE OF REGISTRAR <i>John Doe, Registrar</i></p>	
<p>DATE OF SIGNATURE <i>10/10/1901</i></p>		<p>DATE OF SIGNATURE <i>10/10/1901</i></p>	

COPIES OF THIS CERTIFICATE ARE TO BE FURNISHED TO THE
LOCAL HEALTH OFFICER, THE COUNTY CLERK, AND THE
FEDERAL BUREAU OF INVESTIGATION, U.S. DEPARTMENT OF JUSTICE.

08381

8382

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 EASTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 158 GRAHAM ST.	
3. NAME OF DECEASED (Type or print) First FRANK Middle BOWE Last BOWE		4. DATE OF DEATH Month July Day 28 Year 1958	
5. SEX M	6. COLOR OR RACE CO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store dre		10b. KIND OF BUSINESS OR INDUSTRY Port. sherman	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK BOWE		14. MOTHER'S MAIDEN NAME Gertrude White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. ADDRESS General Bowe (same)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 7/27 , 19 58 , to 7/28 , 19 58 , that I last saw the deceased alive on 7/28 , 19 58 , and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12 N. HANSON ST. MD. DATE SIGNED 7/29/58			
ACTUAL SIGNATURE L. J. Eglseder M.D.		PHYSICIAN'S NAME (Type) L. J. Eglseder MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/58	
22c. NAME OF CEMETERY OR CREMATORY MT Zion		22d. LOCATION (City, town, or county) Preston MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Oschell ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR AUG 5 '58	
24b. REGISTRAR'S SIGNATURE W. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8383 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08382

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton md</u>		c. LENGTH OF STAY IN 1b <u>10 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hospital</u>				d. STREET ADDRESS <u>rural</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Boyd</u> Last <u>Boyd</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4 1944</u>	
				9. AGE (in years last birthday) <u>14 1/2</u>		IF UNDER 1 YEAR: Months <u>11</u> Days <u>17</u> Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Penn a</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward Boyd</u>				14. MOTHER'S MAIDEN NAME <u>Shelia McCray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MR. Edward H. Boyd (FATHER)</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cranial hemorrhage + edema</u> <u>850x</u> DUE TO (b) <u>Boating accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>thrown from boat + struck head</u>			
20c. TIME OF INJURY Month <u>July</u> Day <u>22</u> Year <u>1958</u> Hour <u>4:30</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Thales River</u>		20f. (City or town) (County) (State) <u>St. Michaels Tal. md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Lenn M. Welty</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>WELTY</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 23, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chloris Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>St. Michaels md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Hamilton Harrison</u>				ADDRESS <u>St. Michaels md</u>		24a. REC'D. BY REGISTRAR <u>JUL 24 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

+ 8384

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>1309 Needwood Avenue</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Clement</i> Middle <i>E</i> Last <i>Bray</i>				4. DATE OF DEATH Month <i>July</i> Day <i>30</i> Year <i>1958</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>October 9, 1922</i>	
9. AGE (In years last birthday) <i>35</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>		IF UNDER 24 HRS. Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
						12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William C Bray</i>				14. MOTHER'S MAIDEN NAME <i>Marg C Work</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wife</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO <i>u.w.m.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>a.c.v.d</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Prothrombotic</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>July 11, 1957</i> to <i>July 30, 1958</i> that I last saw the deceased alive on <i>July 30, 1958</i> , and that death occurred at <i>5:40 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>P.E. Coy</i>				DATE SIGNED <i>MD. 9/2/58</i>			
PHYSICIAN'S NAME (Type) <i>P.E. Coy</i>				ADDRESS (Street, city or town, state) <i>EASTON MD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>Aug 2, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>	
				22d. LOCATION (City, town, or county) <i>Easton</i>		(State) <i>MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice C. Newman & Son</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>AUG 5 '58</i>	
						24b. REGISTRAR'S SIGNATURE <i>Alb. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08384

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	c. LENGTH OF STAY IN 1b <u>25 mins.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Linden</u> Middle <u>W. Brittingham</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1904</u>
9. AGE (in years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>E.S.P. Co of Md.</u>	11. BIRTHPLACE (State or foreign country) <u>LAUREL DELAWARE</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LARRY W. BRITTINGHAM</u>	
14. MOTHER'S MAIDEN NAME <u>FLORENCE PARSONS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>221-07-4635</u>		17. INFORMANT Address <u>Mrs. JACK Q. GINN, BOWMAN, GEORGIA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured skull - tree limb fall</u> 910.5 DUE TO (b) <u>on limb.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>He was cutting tree limb & it pinched back fracturing skull</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. (City or town) (County) (State) <u>QUEENSTOWN, Q.A. Co., MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. Henry Fisher</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 25, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>LAUREL DELAWARE</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Butler, Jr., of Butler Bros. Centerville, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUL 28 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Fisher</u>	

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HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08385

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newscomb</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>Charles</u> Last <u>Burgess</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wall Digger</u>	
11. BIRTHPLACE (State or foreign country) <u>Springport, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chauncey H. Burgess</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Towns</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>214-32-2378</u>	
17. INFORMANT <u>Delilah F Burgess, Newscomb, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic coronary</u> DUE TO (c) <u>fractured</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Leukemia - lymphocytic</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>7-9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-9</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Spring Hill Cemetery, Easton, Maryland</u> DATE SIGNED <u>7-9-58</u>			
ACTUAL SIGNATURE <u>Wm M Reeker Jr</u> M.D. <u>Michael M</u>			
PHYSICIAN'S NAME (Type) <u>Wm M Reeker Jr</u>			
22a. BURIAL, CREMATION, REMOVAL, (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/12/58</u>	<u>Spring Hill Cemetery</u>	<u>Easton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Williams</u>		24a. REC'D BY REGISTRAR <u>W. L. Couch</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. Couch</u>
DATE <u>JUL 11 '58</u>			

CERTIFICATE OF DEATH

Form 100-1

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Office of Registrar	
13. Name of Informant		14. Relationship to Deceased		15. Signature of Informant	
16. Name of Attending Physician		17. Signature of Attending Physician		18. Date of Signature	
19. Name of Medical Examiner		20. Signature of Medical Examiner		21. Date of Signature	
22. Name of Coroner		23. Signature of Coroner		24. Date of Signature	
25. Name of Burial Place		26. Signature of Burial Place		27. Date of Signature	
28. Name of Funeral Home		29. Signature of Funeral Home		30. Date of Signature	
31. Name of Cemetery		32. Signature of Cemetery		33. Date of Signature	
34. Name of Interment Place		35. Signature of Interment Place		36. Date of Signature	
37. Name of Burial Place		38. Signature of Burial Place		39. Date of Signature	
40. Name of Interment Place		41. Signature of Interment Place		42. Date of Signature	
43. Name of Burial Place		44. Signature of Burial Place		45. Date of Signature	
46. Name of Interment Place		47. Signature of Interment Place		48. Date of Signature	
49. Name of Burial Place		50. Signature of Burial Place		51. Date of Signature	
52. Name of Interment Place		53. Signature of Interment Place		54. Date of Signature	
55. Name of Burial Place		56. Signature of Burial Place		57. Date of Signature	
58. Name of Interment Place		59. Signature of Interment Place		60. Date of Signature	
61. Name of Burial Place		62. Signature of Burial Place		63. Date of Signature	
64. Name of Interment Place		65. Signature of Interment Place		66. Date of Signature	
67. Name of Burial Place		68. Signature of Burial Place		69. Date of Signature	
70. Name of Interment Place		71. Signature of Interment Place		72. Date of Signature	
73. Name of Burial Place		74. Signature of Burial Place		75. Date of Signature	
76. Name of Interment Place		77. Signature of Interment Place		78. Date of Signature	
79. Name of Burial Place		80. Signature of Burial Place		81. Date of Signature	
82. Name of Interment Place		83. Signature of Interment Place		84. Date of Signature	
85. Name of Burial Place		86. Signature of Burial Place		87. Date of Signature	
88. Name of Interment Place		89. Signature of Interment Place		90. Date of Signature	
91. Name of Burial Place		92. Signature of Burial Place		93. Date of Signature	
94. Name of Interment Place		95. Signature of Interment Place		96. Date of Signature	
97. Name of Burial Place		98. Signature of Burial Place		99. Date of Signature	
100. Name of Interment Place		101. Signature of Interment Place		102. Date of Signature	

8386 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 705 Dover st.				e. STREET ADDRESS 1 705 Dover st.			
3. NAME OF DECEASED (Type or print) First Middle Last Levin JAMES Camper				4. DATE OF DEATH Month Day Year 7 19 1958			
5. SEX Male	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-02	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) md	
13. FATHER'S NAME JAME CAMPER				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Hilba Camper, Easton, md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Same DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/19 , 19 58 to 7/19 , 19 58 , that I last saw the deceased alive on July 19 , 19 58 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Raymond T. Webb M.D.				ADDRESS (Street, city or town, state) Easton, md. DATE SIGNED July 19, 1958			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/58		22c. NAME OF CEMETERY OR CREMATORY Richards Cem		22d. LOCATION (City, town, or county) (State) Easton, md	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Doherty, Easton, md. ADDRESS				24a. REC'D BY REGISTRAR JUL 25 '58 DATE JUL 25 '58		24b. REGISTRAR'S SIGNATURE W. B. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Journal of Management Inquiry 18(6)

8387 CERTIFICATE OF DEATH

Reg. Dist. No.

08387

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 55 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queens town 17X-2	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Ethel Mae Carpenter		4. DATE OF DEATH July 5 1958	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 1956
9. AGE (In years last birthday) 19 mos.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Brock, Jr.		14. MOTHER'S MAIDEN NAME Mary Ethel Carpenter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John Carpenter, son, grandfather		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 344X Meningitis (no organism obtained) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hydrocephalus DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 mo 2 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/12 1958 , to 7/5/58 , that I last saw the deceased alive on 7/5 1958 , and that death occurred at 12:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John I Baybutt M.D.		DATE SIGNED 7/5/58	
PHYSICIAN'S NAME (Type) JOHN I BAYBUTT EASTON, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Buried	7/8/58	Cornwell	Queens town, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James Blochell, Baltimore, Md.		24a. REC'D BY REGISTRAR 29 58 DATE	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
OCCASION OF DEATH [Faint handwritten occasion]		CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
CITY [Faint handwritten city]		COUNTY [Faint handwritten county]		STATE [Faint handwritten state]	

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the registrar of the health department, or by the coroner, or by the undertaker, or by the person who has taken charge of the body, or by the person who has taken charge of the funeral. It is to be filled out in duplicate, one copy to be retained by the health department, and the other copy to be retained by the person who has taken charge of the body, or by the person who has taken charge of the funeral.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fremont St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas O'Connell Chester		4. DATE OF DEATH Month July Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1914
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		10b. KIND OF BUSINESS OR INDUSTRY Landscape	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles Harvey		14. MOTHER'S MAIDEN NAME Larcie Chester	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-20-6727	
17. INFORMANT Larcie Dennis		Address St. Michaels, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction, etiology undetermined 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED 7-9-58 ACTUAL SIGNATURE Louis M. M. M. M.D. PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 10-58	
22c. NAME OF CEMETERY OR CREMATORY Old Cemetery		22d. LOCATION (City, town, or county) (State) St. Michaels Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall		24a. REC'D BY REGISTRAR DATE JUL 14 '58	
ADDRESS St. Michael		24b. REGISTRAR'S SIGNATURE W. J. Seach	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of burial place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
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97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

RECEIVED BY THE CLERK OF THE COURT OF COMMON PLEAS
BALTIMORE, MARYLAND
JAN 10 1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8388

CERTIFICATE OF DEATH

Reg. Dist. No.

08389

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>59 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>V.</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 6, 1896</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>17</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Townsend Fox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Mr. Russell D. Cooper (husband)</u>				Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic coronary disease</u> DUE TO (c) <u>Diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 yrs</u> <u>1 yr</u> <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene of leg, amputated 6/9/58</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1946</u> , to <u>7/17/1958</u> , that I last saw the deceased alive on <u>7/17/1958</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. E. Cox</u>				M.D. <u>Easton Md</u>			
PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>				ADDRESS (Street, city or town, state) <u>EARLE AVE EASTON, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery Easton Md</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H. H.</u>				ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8414

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08590

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON RURAL		c. LENGTH OF STAY IN 1b 110 EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 110 EASTON			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 223 Port St				
3. NAME OF DECEASED (Type or print) First LOUIS Middle EDWARD Last COPPER JR.				4. DATE OF DEATH Month JULY Day 3 Year 19 58				
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-36	9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months 22 Days 22	IF UNDER 24 HRS. Hours 22 Min. 22		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? usa		
13. FATHER'S NAME Louis Edward Copper				14. MOTHER'S MAIDEN NAME Gertrude McDaniel				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Gertrude Copper Address Easton, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) floating on inner tube, couldnt swim, lost tube						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7-3-58 p. m. 1:30P		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tred Avon River nr Easton		20f. (City or town) (County) (State) Talbot Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Lynn M. Welty EXAMINER'S NAME (Type) Welty				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 7-7-58
22a. BURIAL CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-7-58		22c. NAME OF CEMETERY OR CREMATORY Trappe		22d. LOCATION (City, town, or county) (State) Trappe Talbot Md		
23. FUNERAL DIRECTOR'S SIGNATURE James B. Baskin, Easton, Md.				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE JUL 14 '58		24b. REGISTRAR'S SIGNATURE W. A. Beach

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Previous Illnesses		Medical History	
Family History		Social History		Physical Examination		Mental Examination	
Autopsy		Toxicology		Microscopic Examination		Radiological Examination	
Laboratory Tests		X-ray		ECG		Other Tests	
Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Medical Examiner	
Date of Examination		Time of Examination		Place of Examination		City and State	

CERTIFICATE OF DEATH

08391

Reg. Dist. No.

8389

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HURLOCK</u> 09X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>RT. #1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL CORKRAN</u>		4. DATE OF DEATH Month Day Year <u>JULY 12 1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/11/58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>GROVER CORKRAN, JR.</u>		14. MOTHER'S MAIDEN NAME <u>NORMA G. DONOVAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. GROVER CORKRAN</u>		Address <u>RT. 1, Hurlock, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory distress → arrest</u> <u>768.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septic</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/12</u> , 19 <u>58</u> , to <u>7/12</u> , 19 <u>58</u> that I last saw the deceased alive on <u>7/12</u> , 19 <u>58</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Barbara Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Box 185, Oxford, Md</u> DATE SIGNED <u>7/12/58</u>	
PHYSICIAN'S NAME (Type) <u>BARBARA WILLIAMS</u>		<u>Box 185, Oxford, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/14/58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Iron Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>New Federalsburg, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JJ Trampton, Son</u> ADDRESS <u>Federalsburg Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 16 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN
may be retained by the hospital or
TO FUNERAL DIRECTOR: After
page 3 should be detached

The law requires that the death certificate be executed with
the attending physician and completely
burial-transit permit. Then please remove carbon papers. Page
-1 and in any event with-- 72

ath. Page 4

funeral director,
ould be filed with

CERTIFICATE OF DEATH

Reg. Dist. No.

08392

8415

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Tilghman</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Tilghman (BAR NECK)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Burton</u> Last <u>Eddy</u>		4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1914</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Danbury Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Tres</u>		14. MOTHER'S MAIDEN NAME <u>Florence Burton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Robert W. Trever, M.D.</u>		Address <u>Easton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>975x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Suicide</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Under psychiatric treatment</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Last seen at 11 PM 7-18. Spoke of suicide. Removed from water off Bar neck at 10:15 AM 7-19-58</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bar neck (Conn.)</u>		20f. (City or town) <u>Easton</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>11 PM 7-18</u> to <u>7-19</u> , that I last saw the deceased alive on <u>7-18</u> , and that death occurred <u>between 11 PM and dawn 7-19</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D. <u>—</u> ADDRESS (Street, city or town, state) <u>Med Arts Bldg. Easton, Md.</u> DATE SIGNED <u>7-19</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/21/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chilist Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Harrison, St. Michaels, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

the registrar prior to burial, or removal, within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN DOE</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>1930-01-15</i>		5. PLACE OF BIRTH <i>Baltimore, Maryland</i>	
6. OCCUPATION <i>Teacher</i>		7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>1955-06-10</i>		9. NAME OF SPOUSE <i>JANE DOE</i>		10. PLACE OF MARRIAGE <i>Baltimore, Maryland</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>		13. PLACE OF DEATH <i>Home</i>		14. DATE OF DEATH <i>1975-03-20</i>		15. TIME OF DEATH <i>10:00 AM</i>	
16. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		17. SIGNATURE OF REGISTRAR <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08393

8390

1. PLACE OF DEATH a. COUNTY <u>1a/bot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1a/bot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				e. STREET ADDRESS <u>RFD #3</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Faulkner</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 13, 1891</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NW</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Harrison Faulkner</u>				14. MOTHER'S MAIDEN NAME <u>Anna Wilmina News</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MR. HARRY E. FAULKNER (HUSBAND) Easton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>Cerebellar degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1958</u> Hour a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1958</u> , 19 <u>1958</u> , that I last saw the deceased alive on <u>1958</u> , and that death occurred on <u>5:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. W. 25th St. Baltimore, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>July 16, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Upper Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Trappe, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Keonam</u> ADDRESS <u>450 W. Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>Jul 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

08394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tilghman</i>		c. LENGTH OF STAY IN 1b <i>Two years</i> x <i>Tilghman</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>FRANCES M. FRAMPTON</i>		4. DATE OF DEATH Month <i>7</i> - Day <i>5</i> - Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14, 1908</i>
9. AGE (In years last birthday) <i>50</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Tenn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Samuel Lewis</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>243-10-3507</i>	
17. INFORMANT <i>Gilbert Frampton Tilghman Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>inoperable cancer, gall bladder</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 1, 1958</i> to <i>July 5, 1958</i> , that I last saw the deceased alive on <i>July 1, 1958</i> , and that death occurred at <i>Tilghman Md</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Guy M. Beefer</i> M.D.		DATE SIGNED <i>Tilghman Md</i>	
PHYSICIAN'S NAME (Type) <i>GUY M. BEEFER</i> Sr			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>7-5-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Tilghman Mt.</i>	22d. LOCATION (City, town, or county) (State) <i>Tilghman, Talbot Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Deedmore Tilghman</i>		24. REC'D BY REGISTRAR <i>W. J. ...</i>	
ADDRESS		DATE <i>JUL 8 '58</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
SEX		AGE		OCCUPATION	
MARRIAGE		EDUCATION		RELIGION	
BIRTH		DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PERMANENCE		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
FAMILY HISTORY		SOCIAL HISTORY		LABORATORY	
SMOKING		ALCOHOL		DRUGS	
DIET		EXERCISE		STRESS	
ENVIRONMENT		TRAVEL		INJURY	
OCCUPATIONAL		HOBBIES		PAST HISTORY	
FAMILY		FRIENDS		CARETAKER	
WITNESSES		CORONER		BURIAL	
SIGNATURE		DATE		PLACE	

This certificate is to be filled out by the attending physician or the coroner. It is to be filed in the office of the State Department of Health, Baltimore, Maryland.

8391

CERTIFICATE OF DEATH

08395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN TB <u>32 1/2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST Michaels</u>			
				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES ROBERT</u> <u>Hailey</u>				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1958</u>	
				9. AGE (In years lost birthday) yrs. <u>32</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Hailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NONE</u>				17. INFORMANT Address <u>Box 487 St Michaels, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN DISEASE AND DEATH <u>32 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-10</u> , 19 <u>58</u> , to <u>7-11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-11</u> , 19 <u>58</u> , and that death occurred at <u>3:25 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Lane Wroth</u> M.D.				ADDRESS (Street, city or town, state) <u>Box 487 St Michaels, Md</u> DATE SIGNED <u>7-11-58</u>			
PHYSICIAN'S NAME (Type) <u>R. LANE Wroth</u>				LOCATION (City, town, or county) (State) <u>Box 487 St Michaels, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Incineration</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital Easton</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUL 18 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8392

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton Md</i>		c. LENGTH OF STAY IN 1b <i>70 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>1708 Indebro</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Edna</i> Middle <i>Speakman</i> Last <i>Hammors</i>				4. DATE OF DEATH Month <i>July</i> Day <i>31</i> Year <i>1958</i>			
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 27 1880</i>	9. AGE (In years last birthday) <i>78</i> yrs	IF UNDER 1 YEAR Months <i>2</i> Days <i>4</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Henry Speakman</i>				14. MOTHER'S MAIDEN NAME <i>Emma Gillingham</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Name <i>Dr. W. J. Hammors</i> Address <i>Easton Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> <i>331x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Cerebral atherosclerosis</i> DUE TO (c) <i></i>						INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> <i>(?)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Cerebral hypoxia</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>47</i> , to <i>31 July</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>31 July</i> , 19 <i>58</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Easton Maryland</i> DATE SIGNED <i>Aug 3</i>							
ACTUAL SIGNATURE <i>Thorston Harrison</i> M.D.				PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Aug 4, 58</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Fort Detrick</i>		22d. LOCATION (City, town or county) (State) <i>Bladesburg Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bladesburg</i> ADDRESS <i>Easton Md</i>				24a. REC'D BY REGISTRAR DATE <i>AUG 6 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Bladesburg</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G232 8-20-58 et

CERTIFICATE OF DEATH

8417

Reg. Dist. No.

08397

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TILGHMAN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TILGHMAN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MILTON</u> Middle <u>B.</u> Last <u>HARRISON</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 23, 1906</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>2</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISHERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11. BIRTHPLACE (State or foreign country) <u>TILGHMAN MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>JRA B. HARRISON</u>				14. MOTHER'S MAIDEN NAME <u>ELSIE BRUNWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W. II</u>				16. SOCIAL SECURITY NO. <u>217-16-3537</u>			
17. INFORMANT Address <u>Mrs Margaret Harrison Tilghman Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> 420.1 DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 16, 1958</u> to <u>July 16, 1958</u> , that I last saw the deceased alive on <u>July 16, 1958</u> , and that death occurred at <u>24</u> M from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Tilghman Md</u> DATE SIGNED <u>July 16, 1958</u>							
ACTUAL SIGNATURE <u>GUY M REESER Sr</u> M.D.							
PHYSICIAN'S NAME (Type) <u>GUY M REESER Sr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 18, 1958</u>		<u>Tilghman Cemetery</u>		<u>Tilghman Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>S. Hamilton Harrison St. Michaels Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8418

CERTIFICATE OF DEATH

Reg. Dist. No.

08398

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Talbot | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
rural Easton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
rural Easton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED
(Type or print) MERRITT L HOLDEN | | 4. DATE OF DEATH
Month July Day 29 Year 19 58 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 5, 1898 |
| 9. AGE (In years last birthday)
60 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
George H. Holden | | 14. MOTHER'S MAIDEN NAME
Julia Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
219-34-3981 | |
| 17. INFORMANT
Mrs. Merritt L. Holden | | Address
Easton, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Liver
156.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
6 mos | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. 11 p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 7, 1958 to 7/29/58 , that I last saw the deceased alive on 7/25/58 , and that death occurred at 4:45 A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED Aug 1 1958 | | | |
| ACTUAL SIGNATURE Dr. Evans P. Cox M.D. | | PHYSICIAN'S NAME (Type) Dr. Evans P. Cox Easton, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
July 31, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Spring Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Easton, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Maurice E. Newnam & Son | | ADDRESS
Easton, Md. | |
| 24a. REC'D BY REGISTRAR
DATE Aug 1 1958 | | 24b. REGISTRAR'S SIGNATURE
John L. Smith | |

CERTIFICATE OF DEATH

Reg. Dist. No. 88399

8393

| | | | | | | | |
|--|--|--|---|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <i>Talbot</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i> | | | | c. LENGTH OF STAY IN 1b <i>8 days.</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i> | | | | d. STREET ADDRESS <i>1427 South Street</i> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Nettie</i> Middle <i>Howard</i> Last <i>Howard</i> | | | | 4. DATE OF DEATH Month <i>July</i> Day <i>10</i> Year <i>1958</i> | | | |
| 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>C</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>April 10, 1889</i> | |
| 9. AGE (In years last birthday) <i>69 yrs.</i> | | IF UNDER 1 YEAR Months <i>6</i> Days <i>9</i> Hours <i>10</i> Min. | | IF UNDER 24 HRS. Months <i>6</i> Days <i>9</i> Hours <i>10</i> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unknown</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>unknown</i> | | | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> | | | |
| 13. FATHER'S NAME <i>Charles Howard</i> | | | | 14. MOTHER'S MARDEN NAME <i>Carrie Powell</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>unknown</i> | | | | 16. SOCIAL SECURITY NO. <i>unknown</i> | | | |
| 17. INFORMANT <i>Virginia Howard (sister)</i> | | | | Address <i>410 South St Easton, Md</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Calapic Acute & Chronic</i>
<i>421.1</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <i>19</i> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Patologist</i> , 19 <i>58</i> to <i>11 July 58</i> , that I last saw the deceased alive on <i>7-45 P</i> , and that death occurred at <i>2195 W 25th St</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>E. C. H. Schmidt</i> | | | | ADDRESS (Street, city or town, state) <i>2195 W 25th St Easton, Md</i> | | | |
| PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i> | | | | DATE SIGNED <i>11 July 58</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>7/14/58</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Richards Cem</i> | | 22d. LOCATION (City, town, or county) (State) <i>Easton, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Doshell</i> | | | | ADDRESS <i>Easton, Md.</i> | | 24a. REC'D BY REGISTRAR <i>DATE JUL 16 '58</i> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Albrecht</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8394
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>TALBOT</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> p. COUNTY <u>TALBOT</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | | | c. LENGTH OF STAY IN 1b <u>4 3/4 hr.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>1</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Christopher Leigh Hunt</u> | | | | 4. DATE OF DEATH <u>July 15 1958</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>Sept. 5 1956</u> | | 9. AGE (In years lost birthday) <u>2 yrs.</u> | |
| | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Daniel A. Hunt</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Jean Brownley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Daniel A. Hunt, Oxford, Md.</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>
<u>883.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumothorax - (R)</u>
DUE TO (c) <u>Esophageal Rupture - Stenosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>1 hour</u>
<u>6 hours</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Child swallowed caustic agent 2 months prior</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Caustic agent in home</u> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>to death</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | |
| | | | | 20f. (City or town) <u>Oxford, Talbot Md</u> (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>July 7, 1958</u> , to <u>July 15, 1958</u> , that I last saw the deceased alive on <u>July 15, 1958</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Bowman Williams MD</u> | | | | ADDRESS (Street, city or town, state) <u>Box 185, Oxford Md</u> DATE SIGNED <u>7/15/58</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>7/17/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>OXFORD CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>OXFORD MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Canoll, Easton Md</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR <u>JUL 18 58</u> DATE | | 24b. REGISTRAR'S SIGNATURE <u>W. Hampton Canoll</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8395

CERTIFICATE OF DEATH

Reg. Dist. No. 08401

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Maryland b. COUNTY Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg 05x-2v | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital | | d. STREET ADDRESS Rt 1 Box 2390 | |
| 3. NAME OF DECEASED (Type or print)
First George W. Middle Johnson Last Johnson | | 4. DATE OF DEATH
Month July Day 15 Year 1958 | |
| 5. SEX M | 6. COLOR OR RACE Wcol | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
DECEMBER 24, 1872 |
| 9. AGE (In years last birthday) 85 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months 1 Days 15 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY FARM | |
| 11. BIRTHPLACE (State or foreign country) CAROLINE CO. MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HENRY JOHNSON | | 14. MOTHER'S MAIDEN NAME SARAH (MAIDEN NAME UNKNOWN) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT THOMAS JOHNSON | | Address FEDERALSBURG, MD. RFD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thrombosis left middle cerebral artery
DUE TO 332x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 332x
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 19 to 19 , that I last saw the deceased alive on 19 and that death occurred at 11:30 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 219 S. Washington St. Federalburg, Md. DATE SIGNED July 15, 1958 | | | |
| ACTUAL SIGNATURE E. C. H. Schmid | | PHYSICIAN'S NAME (Type) E. C. H. Schmid | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF JULY 19, 1958 | 22c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY | 22d. LOCATION (City, town, or county) (State) NEAR FEDERALSBURG, MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. J. Thompson Sen. | | ADDRESS Federalburg, Md. | |
| 24a. REC'D BY REGISTRAR JUL 22 '58 | | 24b. REGISTRAR'S SIGNATURE W. J. Leach | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8419

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 9 Film G232 8-5-58 et

Reg. Dist. No. 08402

FOR STATE HEALTH DEPT.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY TALBOT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE VIRGINIA b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
OUTSIDE EASTON | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BELLHAVEN | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First ONELL Middle Supreme Last KELLAM | | 4. DATE OF DEATH
Month JULY Day 19 Year 19 58 | |
| 5. SEX
male | 6. COLOR OR RACE
colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 4 1922 |
| 9. AGE (In yrs. last birthday)
36 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
cannery | |
| 11. BIRTHPLACE (State or foreign country)
Accomack County, Va | | 12. CITIZEN OF WHAT COUNTRY?
usa | |
| 13. FATHER'S NAME
Samuel Ewell | | 14. MOTHER'S MAIDEN NAME
Georgie Mae Kellam | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
YES World War II | | 16. SOCIAL SECURITY NO.
224-20-0254 | |
| 17. INFORMANT
Georgie Kellam | | 18. ADDRESS
R.F.D. Painter, Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GSW CHEST
981X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)
INTERVAL BETWEEN ONSET AND DEATH
IMMED | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
shot at close range with shotgun-almost instant exsanguination | |
| 20c. TIME OF INJURY
Month, Day, Year
2:30P. 7-19-58 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
H&J factory | 20f. (City or town) (County) (State)
nr Easton Talbot Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Louis S. Welty | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Louis S. Welty | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial July 26, 1958 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY
Shiloh Cemetery | | 22d. LOCATION (City, town, or county) (State)
Boston Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. Edgar Thomas | | 24a. REC'D BY REGISTRAR
JUL 23 58 | |
| ADDRESS
Accomack Va | | 24b. REGISTRAR'S SIGNATURE
W. H. Smith | |

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>TALBOT</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>EASTON</u> | | c. LENGTH OF STAY IN 1b
. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>MEMORIAL HOSPITAL</u> | | d. STREET ADDRESS
<u>1</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>EUGENIA M. LANG</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>26</u> Year <u>1958</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>JAN. 20, 1885</u> |
| 9. AGE (In years last birthday)
<u>73</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>-</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>GERMANY</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>ROBERT LEFORD</u> | | 14. MOTHER'S MAIDEN NAME
<u>EMILY WELDY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>MRS. ROBERT RAUSCH</u> | | Address
<u>ST. MICHAELS</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>
<u>430.1</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic coronary heart d</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>cardiac failure</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>7-22-58</u> , 19 <u>58</u> , to <u>7-26-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-26-58</u> , 19 <u>58</u> , and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Norman D. Marshall</u> | | DATE SIGNED
<u>7-26-58</u> | |
| PHYSICIAN'S NAME (Type)
<u>Guy M. Reese</u> | | M.D. <u>St. Michaels Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>July 28, 1958</u> | | 22b. DATE THEREOF
<u>July 28, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Oliver</u> | | 22d. LOCATION (City, town, or county) (State)
<u>St. Michaels Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Norman D. Marshall</u> | | ADDRESS
<u>St. Michael, Md</u> | |
| 24a. REC'D BY REGISTRAR
<u>158</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Deed</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

6500

| | | | | | |
|--|--|--|--|--|--|
| <p>1. NAME OF DECEASED
<i>John Doe</i></p> | | <p>2. SEX
<i>Male</i></p> | | <p>3. AGE
<i>45</i></p> | |
| <p>4. DATE OF DEATH
<i>Jan 15 1925</i></p> | | <p>5. TIME OF DEATH
<i>10:30 AM</i></p> | | <p>6. PLACE OF DEATH
<i>Home</i></p> | |
| <p>7. CAUSE OF DEATH
<i>Heart Disease</i></p> | | <p>8. DISEASE OR INJURY
<i>Myocardial Infarction</i></p> | | <p>9. MANNER OF DEATH
<i>Natural</i></p> | |
| <p>10. SIGNATURE OF PHYSICIAN
<i>Dr. J. H. Smith</i></p> | | <p>11. SIGNATURE OF WITNESSES
<i>John Doe, Jr.</i></p> | | <p>12. SIGNATURE OF DECEASED
<i>John Doe</i></p> | |
| <p>13. SIGNATURE OF REGISTRAR
<i>John Doe</i></p> | | <p>14. SIGNATURE OF CLERK
<i>John Doe</i></p> | | <p>15. SIGNATURE OF JURY
<i>John Doe</i></p> | |

THE STATE OF MARYLAND, ss. I, the undersigned, Clerk of the State Department of Health, do hereby certify that the foregoing is a true and correct copy of the original record on file in the office of the State Department of Health, Baltimore, Maryland, this 15th day of January, 1925.

WITNESSED MY HAND AND SEAL OF OFFICE this 15th day of January, 1925.

CLERK OF THE STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8397

CERTIFICATE OF DEATH

Item 2 See: Birth Cert. et

Reg. Dist. No. 08404

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY TALBOT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON 12 days. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30 3 Vol-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Easton Memorial Hosp | | d. STREET ADDRESS 2213 Sidney Avenue | |
| 3. NAME OF DECEASED (Type or print) Nathan Willi Lindell | | 4. DATE OF DEATH 7 - 9 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-28-58 |
| 9. AGE (In years last birthday) 12 | | 10. IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Nathan Willi Lindell | | 14. MOTHER'S MAIDEN NAME EDNA LORRAINE HALTZNER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Lorraine Haltzner | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 776X Prematurity
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 11 days
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/28 , 1958, to 7/9 , 1958, that I last saw the deceased alive on 7/7 , 1958, and that death occurred at 10:35 A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Irvin G. Hoyt M.D. | | ADDRESS (Street, city or town, state) Queenstown, Md DATE SIGNED 7/10/58 | |
| PHYSICIAN'S NAME (Type) Irvin G. Hoyt MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 7-10-58 | 22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Mem. Cem. | 22d. LOCATION (City, town, or county) (State) Wash. Blvd. Balto., Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Farace, Inc. | | ADDRESS 712-14 E. NORTH AVE #2 DATE JUL 11 '58 | |
| 24b. REGISTRAR'S SIGNATURE W. L. Leach | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2080315XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8420

CERTIFICATE OF DEATH

Reg. Dist. No.

08405

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Caroline | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
St. Michaels, | | | | c. LENGTH OF STAY IN 1b
24 hrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Rio Vista Nursing Home | | | | d. STREET ADDRESS
05X-2 ✓ | | | |
| 3. NAME OF DECEASED (Type or print)
First ROBERT Middle S. Last MACKINNON | | | | 4. DATE OF DEATH
Month July Day 7, Year 19 58 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
December 21, 1873 | | 9. AGE (In years last birthday)
84 yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
(ret) U.S. Dept of Ag. | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | | 11. BIRTHPLACE (State or foreign country)
St. Johnsbury, Vt. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | 13. FATHER'S NAME
Robert Mackinnon | | | |
| 14. MOTHER'S MAIDEN NAME
Mary B. Newell | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes | | | |
| 16. SOCIAL SECURITY NO.
--- | | | | 17. INFORMANT
Hugh A. Mackinnon, Box 656, Preston, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis. Carcinoma of the Bladder | | | | | | INTERVAL BETWEEN ONSET AND DEATH
15 minutes
Unknown | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7-1 , 19 58 , to 7-7 , 19 58 , that I last saw the deceased alive on 7-6 , 19 58 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED _____ | | | | | | | |
| ACTUAL SIGNATURE Robert W. Trever | | | | M.D. Easton, Md. | | | |
| PHYSICIAN'S NAME (Type) Robert W. TREVER | | | | EASTON, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/10/58 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
S. Hamilton Harrison, St. Michaels | | | | 24a. REC'D BY REGISTRAR
DATE JUL 10 '58 | | 24b. REGISTRAR'S SIGNATURE
W. H. Smith | |

08406

Reg. Dist. No.

| | | | |
|---|------------------------------|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Easton</u> | | c. LENGTH OF STAY IN lb
<u>7 hrs.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Memorial Hospital</u> | | d. STREET ADDRESS
<u>306 Maple Avenue</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Blanche</u> First <u>McCreary</u> Middle <u>McCrea</u> Last | | 4. DATE OF DEATH
Month <u>July</u> Day <u>29</u> Year <u>1958</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 14, 1913</u> |
| 9. AGE (In years last birthday)
<u>45</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>House work</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Delaware</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | |
| 13. FATHER'S NAME
<u>Tennessee Thomas</u> | | 14. MOTHER'S MAIDEN NAME
<u>Martha Hayman</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>420.1</u> | |
| 17. INFORMANT
<u>Husband M.</u> | | Address
<u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u> </u> <u> </u> <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> <u> </u> <u> </u> | |
| 21. I certify that I attended the deceased from <u>7/29</u> 19 <u>58</u> , to <u>7/29/58</u> 19 <u> </u> , that I last saw the deceased alive on <u>7/29/58</u> 19 <u> </u> , and that death occurred at <u>5:15 P.</u> M., from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED
<u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> | |
| ACTUAL SIGNATURE
<u>Arthur B. Cecil</u> | | M.D. <u>EASTON MARYLAND</u> | |
| PHYSICIAN'S NAME (Type)
<u>ARTHUR B. CECIL M.D. EASTON Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Buried</u> | | 22b. DATE THEREOF
<u>Aug 1, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Albans Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Federalburg, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Harry Williams</u> | | ADDRESS
<u>Federalburg, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u> </u> | | 24b. REGISTRAR'S SIGNATURE
<u> </u> | |
| DATE
<u>AUG 5 '58</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8399 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. LENGTH OF STAY IN 1b <u>6 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Molly</u> Middle <u>Mills</u> Last <u>Mills</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1958</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 14 1879</u> |
| 9. AGE (In years last birthday) <u>79</u> ts. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Spencer</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Thomas</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | |
| 17. INFORMANT <u>Thomas Mills</u> Address <u>Baltimore, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Dis.</u>
DUE TO (c) <u>5 yr.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>
of work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>46</u> , to <u>11 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 July</u> , 19 <u>58</u> , and that death occurred on <u>11 July</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>R. Lane Wroth</u> M.D. | | ADDRESS (Street, city or town, state) <u>St. Michaels, Md.</u> DATE SIGNED <u>7-13-58</u> | |
| PHYSICIAN'S NAME (Type) <u>R. LANE WROTH</u> | | <u>ST. MICHAELS, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>7/15/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Corbitt</u> ADDRESS <u>Easton, Md.</u> | | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE <u>Att. Corbitt</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8400

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Easton</u> | | | | c. LENGTH OF STAY IN TB
<u>16 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Memorial Hospital</u> | | | | d. STREET ADDRESS
<u>CHOPTANK</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Louis</u> Middle <u>Monath</u> Last <u>Monath</u> | | | | 4. DATE OF DEATH
Month <u>7</u> - Day <u>12</u> Year <u>1958</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11/15/88</u> | 9. AGE (In years last birthday)
<u>69</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Truck Driver</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>State Roads Comm</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>unknown</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>213-16-7887</u> | | 17. INFORMANT
<u>Mrs. Daisy Monath (wife)</u> Address <u>Preston Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
<u>421.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Calcific aortic stenosis - cardiac failure, compensated at rest</u>
(c) <u>Unknown</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>58</u> , to <u>7-12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-12</u> , 19 <u>58</u> , and that death occurred at <u>7-PM</u> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state)
<u>Medical Arts Bldg., Easton</u> | | | | DATE SIGNED
<u>7-16-58</u> | | | |
| ACTUAL SIGNATURE
<u>Robert W. Trever</u> | | | | M.D. <u>Medical Arts Bldg., Easton, Md.</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>Robert W. Trever</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>July 16, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>JUNIOR ORDER CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>NEAR PRESTON, MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>J. J. Trampton, Son</u> | | | | ADDRESS
<u>Federalburg, Md</u> | | 24a. REC'D BY REGISTRAR
DATE <u>JUL 22 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>W. H. Smith</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8401

Item 7 Film G232 7-30-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

08400

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> <u>DoA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Oxford</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Robert J Myers</u> | | 4. DATE OF DEATH <u>7</u> <u>16</u> <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 7, 1870</u> |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Wm H. Myers</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Ruby Jackson</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Wm H. Myers</u> Address <u>Oxford Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
DUE TO <u>331X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u>
DUE TO (c) <u>331X</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart failure</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>16 July 58</u> , 19 <u>58</u> , to <u>16 July 58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>16 July 58</u> , 19 <u>58</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Howard B. Kinnaman</u> M.D. | | ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> | |
| PHYSICIAN'S NAME (Type) <u>Howard B. Kinnaman</u> | | DATE SIGNED <u>July 19, 58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>July 19, 58</u> | 22b. DATE THEREOF <u>July 19, 58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Oxford</u> | 22d. LOCATION (City, town, or county) (State) <u>Oxford Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Black</u> ADDRESS <u>Easton Md</u> | | 24a. REC'D BY REGISTRAR <u>DATE JUL 24 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>W. Leach</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1001

| | | | |
|---|--|--|--|
| NAME OF DECEASED
[Faint text, possibly "JOHN DOE"] | | SEX
[Faint text, possibly "Male"] | |
| AGE
[Faint text, possibly "45"] | | DATE OF BIRTH
[Faint text, possibly "10-15-1880"] | |
| PLACE OF BIRTH
[Faint text, possibly "Baltimore, Md."] | | OCCUPATION
[Faint text, possibly "Teacher"] | |
| MARITAL STATUS
[Faint text, possibly "Married"] | | DATE OF MARRIAGE
[Faint text, possibly "12-1-1905"] | |
| NAME OF SPOUSE
[Faint text, possibly "Jane Doe"] | | DATE OF DEATH
[Faint text, possibly "10-20-1925"] | |
| TIME OF DEATH
[Faint text, possibly "10:30 AM"] | | PLACE OF DEATH
[Faint text, possibly "Home"] | |
| CAUSE OF DEATH
[Faint text, possibly "Heart Disease"] | | MANNER OF DEATH
[Faint text, possibly "Natural"] | |
| SIGNATURE OF PHYSICIAN
[Faint signature] | | SIGNATURE OF REGISTRAR
[Faint signature] | |
| CITY
[Faint text, possibly "Baltimore"] | | COUNTY
[Faint text, possibly "Baltimore"] | |
| STATE
[Faint text, possibly "Maryland"] | | YEAR
[Faint text, possibly "1925"] | |

08410

VS AIS (4)
ISM 9/55

VS AIS (4)
ISM 9/55

VS AIS (4)
ISM 9/55

[illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 08411

8403

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN 1b <u>2 days.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5301 Falls Road Terrace | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>K</u> Last <u>Nield, Jr.</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1958</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 14, 1910</u> | |
| 9. AGE (In years last birthday) <u>48</u> yrs. | | IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u> Hours <u>48</u> Min. | | IF UNDER 24 HRS. Months <u>4</u> Days <u>18</u> Hours <u>48</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bakery</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Harry K Nield, Sr</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eden Van Doren</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>Wife</u> | | | |
| 17. INFORMANT <u>Wife</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction - acute</u>
420.1 DUE TO <u>atherosclerotic coronary heart d.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u>
DUE TO (c) <u>—</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac failure, shock - Terminal</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u>—</u> p. m. <u>—</u> 19 <u>58</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>7-20</u> , 19 <u>58</u> , to <u>7-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-21</u> , 19 <u>58</u> , and that death occurred at <u>7:35 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Guy M. Reeser Jr</u> M.D. | | | | <u>Strickland md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Guy M Reeser Jr</u> | | | | <u>7-21-58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/24/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Abnoid Ridge</u> | | 22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam. J. Tiekner & Sons - Balt</u> | | | | ADDRESS <u>17th</u> | | | |
| 24a. REC'D BY REGISTRAR <u>JUL 23 '58</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>W. Leach</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[The page contains faint, illegible text, likely bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8404

CERTIFICATE OF DEATH

Reg. Dist. No. 08412

| | | | |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | d. STREET ADDRESS <u>125 West Street</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A</u> Last <u>Roberts</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>February 8, 1906</u> |
| 9. AGE (In years last birthday) <u>52</u> yrs. | | IF UNDER 1 YEAR: Months <u>52</u> Days <u>17</u> Hours <u>19</u> Min. <u>58</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Board of Education</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Walter Roberts</u> | | 14. MOTHER'S MAIDEN NAME <u>Natie Howard</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Yan E. Roberts (wife) Anne</u> | |

| | | | |
|--|---|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>540.0 MALNUTRITION</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GASTRIC ULCER</u>
DUE TO
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 WKS</u>
<u>YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 <u>58</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>JUNE 15, 1958</u> to <u>JULY 17, 1958</u> , that I last saw the deceased alive on <u>JULY 17, 1958</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Donald F. Bartley</u> M.D. | | ADDRESS (Street, city or town, state) <u>9 N. HANSON ST. EASTON, MD.</u> | |
| DATE SIGNED <u>7-17-58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Donald F. Bartley</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>7/31/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Derhiell</u> ADDRESS <u>Easton, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE JUL 25 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Derhiell</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2401

See District

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED
<i>JOHN J. BROWN</i> | | 2. SEX
<i>Male</i> | | 3. AGE
<i>65</i> | | 4. DATE OF BIRTH
<i>1900</i> | | 5. PLACE OF BIRTH
<i>St. Louis, Mo.</i> | | 6. OCCUPATION
<i>Retired</i> | |
| 7. MARITAL STATUS
<i>Married</i> | | 8. DATE OF MARRIAGE
<i>1925</i> | | 9. PLACE OF MARRIAGE
<i>Baltimore, Md.</i> | | 10. NAME OF SPOUSE
<i>Mary Ann Brown</i> | | 11. DATE OF DEATH
<i>1965</i> | | 12. PLACE OF DEATH
<i>Home</i> | |
| 13. CAUSE OF DEATH
<i>Heart Disease</i> | | 14. MANNER OF DEATH
<i>Natural</i> | | 15. MEDICAL HISTORY
<i>None</i> | | 16. PREVIOUS ILLNESS
<i>None</i> | | 17. PREVIOUS SURGERY
<i>None</i> | | 18. PREVIOUS TRAUMA
<i>None</i> | |
| 19. SIGNATURE OF PHYSICIAN
<i>John J. Brown</i> | | 20. SIGNATURE OF WITNESS
<i>Mary Ann Brown</i> | | 21. SIGNATURE OF DECEASED
<i>John J. Brown</i> | | 22. SIGNATURE OF FUNERAL HOME
<i>John J. Brown</i> | | 23. SIGNATURE OF COUNTY CLERK
<i>John J. Brown</i> | | 24. SIGNATURE OF STATE CLERK
<i>John J. Brown</i> | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD. IT IS NOT VALID FOR ANY OTHER PURPOSES.

10-10-65

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 02327/30/58 gpi

8405

CERTIFICATE OF DEATH

08413

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Caroline</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN 1b <u>4 days.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u> | | | | d. STREET ADDRESS <u>Federalburg, Md. 208 Greenridge Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Reuben</u> Middle <u>D</u> Last <u>Segars</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 5, 1889 | |
| 9. AGE (In years, lost birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>23</u> Hours <u>19</u> Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Security Bureau</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Reuben Segars</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Not known</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>214-347116</u> | | 17. INFORMANT Address <u>wife Mrs. Maud Segars</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u>
<u>570.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent prostatectomy</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>21st Nov. 1958</u> , 19 <u>58</u> , to <u>24th Nov. 1958</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>24th Nov. 1958</u> , 19 <u>58</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> | | | | ADDRESS (Street, city or town, state) <u>219 S. Washington St. Federalburg, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> | | | | DATE SIGNED <u>24 Nov 58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>July 26, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Federalburg, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Williams</u> | | | | ADDRESS <u>Federalburg, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>Jul 25 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

08414

8406

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <i>Talbot</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Easton.</i> | | | | c. LENGTH OF STAY IN 1b
<i>29 days.</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Memorial Hospital</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>Baby Girl</i> Middle <i>Shores</i> Last <i>Shores</i> | | | | 4. DATE OF DEATH
Month <i>July</i> Day <i>24</i> Year <i>1958</i> | | | |
| 5. SEX
<i>Female</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>June 25, 1958</i> | |
| 9. AGE (In years last birthday)
<i>29</i> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>None</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>None</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 13. FATHER'S NAME
<i>James H. Shores</i> | | 14. MOTHER'S MAIDEN NAME
<i>Shirley Bambarly</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>Mr. James H. Shores (father)</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Prematurity</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>7 days</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>25 June, 1958</i> , to <i>24 July, 1958</i> , that I last saw the deceased alive on <i>24 July, 1958</i> , and that death occurred at <i>6:45 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<i>R. New Worth</i> | | | | ADDRESS (Street, city or town, state)
<i>Box 487, St. Michaels, Md.</i> | | | |
| DATE SIGNED
<i>7-25-58</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>7/25/58</i> | | 22c. NAME OF CEMETERY OR CREMATORY
<i>Springhill Cemetery</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Easton Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>St. Harrison</i> | | | | ADDRESS
<i>St. Michaels Md.</i> | | 24a. REC'D BY REGISTRAR
DATE <i>JUL 28 '58</i> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<i>W. T. South</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2080243XV0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

8407

CERTIFICATE OF DEATH

08415

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Talbot</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>
c. LENGTH OF STAY IN 1b <u>13 days</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u>
b. COUNTY <u>Dorchester</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>
d. STREET ADDRESS <u>R.T. #2</u>
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First <u>Edward</u> Middle <u>Stanley</u> Last <u>Stanley</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>6</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 16, 1915</u>
9. AGE (In years last birthday) <u>42</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Henry Stanley</u> | | 14. MOTHER'S MAIDEN NAME <u>Ella Mollock</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-16-5578</u> | |
| 17. INFORMANT <u>Ruby S. Young (sister)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u>
181.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>6/23</u> , 19 <u>58</u> , to <u>7/6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/5</u> , 19 <u>58</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>P. E. Cox</u> | | DATE SIGNED <u>July 14, 1958</u> | |
| PHYSICIAN'S NAME (Type) <u>P. E. Cox</u> | | ADDRESS (Street, city or town, state) <u>Cambridge, Maryland</u> | |
| 22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>7/9/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>York Neck</u> | 22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. McLaughlin</u> | | 24a. REC'D BY REGISTRAR <u>Jul 14 '58</u> | |
| ADDRESS <u>317 High St. Cambridge, Md</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|--------|--|--------|--|---------|--|------------------|--|--------------------|--|------------------|--|--------------------|--|-------------------|--|---------------------|--|----------------------------|--|----------------------------|--|-------------------------------|--|----------------------------|--|--------------------------|--|-----------------------|--|------------------------|--|------------------------|--|-------------------------|--|----------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF PHYSICIAN | | 13. SIGNATURE OF FUNERAL HOME | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF CORONER | | 16. SIGNATURE OF JURY | | 17. SIGNATURE OF JUDGE | | 18. SIGNATURE OF CLERK | | 19. SIGNATURE OF NOTARY | | 20. SIGNATURE OF OTHER OFFICIALS | |
| JAMES EARL RAY | | Male | | 35 | | White | | 1928 | | Memphis, Tennessee | | April 4, 1968 | | Memphis, Tennessee | | Shot | | Homicide | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | | |

100-101 4/9/68 Mark West Dorchester Co Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8421 CERTIFICATE OF DEATH

Reg. Dist. No. 08418

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY TALBOT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE MARYLAND b. COUNTY TALBOT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural OXFORD | | | | c. LENGTH OF STAY IN 1b 86 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) CORA First DELAHAY Middle STEWART Last | | | | 4. DATE OF DEATH JULY Month 9 Day 19 Year 58 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH AUG. 1, 1872 | |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR Months 11 Days 9 | | IF UNDER 24 HRS. Hours 11 Min. 9 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) INDIANA | |
| 12. CITIZEN OF WHAT COUNTRY? US | | | | | | | |
| 13. FATHER'S NAME RICHARD HAMILTON DELAHAY | | | | 14. MOTHER'S MAIDEN NAME AMELIA J. JONES | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT MISS MARGARET STEWART Address EASTON, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arterio-sclerotic heart disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) — | | | | | | | INTERVAL BETWEEN ONSET AND DEATH years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from July 5, 1958 to July 9, 1958 , that I last saw the deceased alive on July 9, 1958 , and that death occurred at 10:47 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Donald F. Bartley M.D. | | | | ADDRESS (Street, city or town, state) 9 N. HANSON ST. EASTON, MD. | | DATE SIGNED 7-9-58 | |
| PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF July 12, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery | | 22d. LOCATION (City, town, or county) (State) MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John R. Williams ADDRESS Easton, Md. | | | | 24a. REC'D BY REGISTRAR Al. Leach DATE JUL 11 '58 | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| DECEASED
NAME
LAST, FIRST, MIDDLE
SEX
AGE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
MARITAL STATUS
COLOR
RELIGION
EDUCATION
SERVICE
GRADE
BRANCH
COMPANY
REGIMENT
DIVISION
CORPS
SERVICE NUMBER
GRADE
BRANCH
COMPANY
REGIMENT
DIVISION
CORPS
SERVICE NUMBER | | PLACE OF DEATH
STREET
CITY
COUNTY
STATE
ZIP CODE
DATE OF DEATH
TIME OF DEATH
PLACE OF DEATH
STREET
CITY
COUNTY
STATE
ZIP CODE | |
| CAUSE OF DEATH
1. IMMEDIATE
2. INTERMEDIATE
3. REMOTE
4. UNKNOWN
5. OTHER | | MANNER OF DEATH
1. ACCIDENT
2. SUICIDE
3. HOMICIDE
4. NATURAL
5. UNKNOWN
6. OTHER | |
| SIGNATURE OF DECEASED
DATE
PLACE
CITY
COUNTY
STATE
ZIP CODE | | SIGNATURE OF WITNESS
DATE
PLACE
CITY
COUNTY
STATE
ZIP CODE | |
| SIGNATURE OF PHYSICIAN
DATE
PLACE
CITY
COUNTY
STATE
ZIP CODE | | SIGNATURE OF CORONER
DATE
PLACE
CITY
COUNTY
STATE
ZIP CODE | |
| SIGNATURE OF JUDGE
DATE
PLACE
CITY
COUNTY
STATE
ZIP CODE | | SIGNATURE OF CLERK
DATE
PLACE
CITY
COUNTY
STATE
ZIP CODE | |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH. IT IS TO BE RETURNED TO THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH. IT IS TO BE RETURNED TO THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

8408

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Easton</u> | | c. LENGTH OF STAY IN 1b
<u>4 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>40 Easton</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Memorial Hospital</u> | | | | d. STREET ADDRESS
<u>1308 S Harrison ST.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Lawrence H</u> Middle <u>Stewart</u> Last <u>Stewart</u> | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>31</u> Year <u>1958</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 29, 1896</u> | | 9. AGE (In years lost birthday) <u>62</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farming</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Farming</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Walter Stewart</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Gertrude Cox</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>215-36-1897</u> | | 17. INFORMANT
<u>Mrs S. H. Stewart Jr.</u> | | Address
<u>Easton Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>
154X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of rectum</u>
DUE TO (c) <u>'N</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>7 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 31, 1958</u> , and that death occurred at <u>4:40 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>P. E. Cox</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>EASTON, MD</u>
<u>EASTON MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Aug 7, 1958</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Spring Hill</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Easton Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. J. Smith</u> | | | | 24a. REC'D BY REGISTRAR
DATE AUG 6 '58 | | 24b. REGISTRAR'S SIGNATURE
<u>W. J. Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8409 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Caroline</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | d. STREET ADDRESS <u>05X 2</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Boy</u> Middle <u>Towers</u> Last | | 4. DATE OF DEATH <u>7</u> - <u>3</u> - <u>1958</u> Month Day Year | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-3-58</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Phillip S. Towers</u> | | 14. MOTHER'S MAIDEN NAME <u>Beth Covey</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 17. INFORMANT <u>Mrs Beth Towers</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>762.0</u> DUE TO <u>Asphyxia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atelectasis</u> DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>7/3</u> 19 <u>58</u> , to <u>7/3</u> 19 <u>58</u> , that I last saw the deceased alive on <u>7/3/58</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Frank M. Anderson</u> | | ADDRESS (Street, city or town, state) <u>Federalsburg, Md.</u> DATE SIGNED <u>7-11-58</u> | |
| PHYSICIAN'S NAME (Type) <u>FRANK M. ANDERSON M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>7/4/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey D. Anderson</u> ADDRESS | | 24b. REC'D BY REGISTRAR <u>DATE JUL 16 '58</u> | 24c. REGISTRAR'S SIGNATURE <u>Alf Leach</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8410

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u> | | | | c. LENGTH OF STAY IN 1b <u>3 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>18 Laurel Street</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph</u> <u>Tray</u> | | | | 4. DATE OF DEATH Month Day Year <u>July</u> <u>31</u> <u>19 58</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 14, 1885</u> | |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentering</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | | | | | | |
| 13. FATHER'S NAME <u>John Tray</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Plummer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>Same</u> | | | |
| 17. INFORMANT Address <u>Mrs Gladys Tray (wife)</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
332x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u>
DUE TO (c) <u>?</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General debility associated with CNS injury</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>7/29</u> , 19 <u>58</u> , to <u>7/31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/31</u> , 19 <u>58</u> , and that death occurred at <u>7:50 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>L. J. Eglseder</u> M.D. <u>12 N. HANSON ST</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>L. J. Eglseder</u> <u>EASTON, MD.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Aug 4, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Springhill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. E. Newman Son Easton</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>AUG 5 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. E. Search</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08420

8411

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Easton | | c. LENGTH OF STAY IN 1b
1 hour | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Rosina Last Trice | | 4. DATE OF DEATH
Month July Day 27 Year 19 58 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 8, 1884 |
| 9. AGE (In years last birthday) yrs. 75 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | |
| 11. BIRTHPLACE (State or foreign country)
New York State | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Amos L. Fishell | | 14. MOTHER'S MAIDEN NAME
Frances Lucinda Weledry | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-07-7715 | |
| 17. INFORMANT
Mrs. Russell E. Merrick, Federalsburg, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Phlebitis, multiple pulmonary emboli. Diabetes 23 yrs | | | INTERVAL BETWEEN ONSET AND DEATH
2 hr |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 19 46 , to July 27 19 58 , that I last saw the deceased alive on July 23 19 58 , and that death occurred at 6:30 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE E. Paul Knotts | | ADDRESS (Street, city or town, state) 406 Market St | |
| PHYSICIAN'S NAME (Type) E. Paul Knotts M.D. | | DATE SIGNED Dent on, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
July 30, 1958 | 22c. NAME OF CEMETERY OR CREMATORY
Hill Crest Cemetery | 22d. LOCATION (City, town, or county) (State)
Federalsburg, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J.J. Frampton and Son, Federalsburg, Maryland | | 24a. REC'D BY REGISTRAR
AUG 5 '58 | 24b. REGISTRAR'S SIGNATURE
Alfred Smith |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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